Medical Shelter Intake
Demographic and Needs Assessment

Contact Information

Date: Time:	Location:
Name Street Address: City: State and Zip: DOB: Sex: Phone: Cell: Height: Weight: Type Residence: Lives □ Alone □ Relative □ Other:	Caregiver Name: Street Address: City: State and Zip: Phone: Cell: Contact 2 Name: Street Address: City: State and Zip: Phone: Cell:
Is resident acutely ill? YES ☐ NO ☐	Is resident on dialysis? YES ☐ NO ☐
Does resident need immediate LTC placement? YES ☐ NO ☐	Does resident have an infectious disease? YES ☐ NO ☐
Will the caregiver remain with the patient?	□ YES □ NO

Equipment Needs, Assist Needs, Impairments

□ Oxygen concentrator ___lpm	□ Incontinence	□ Deaf or serious hearing deficet
□ Oxygen tanks ___lpm	□ Assist with transfers	□ Blind or serious visual deficet
□ Tube feedings	□ Assist with bathing	□ Speech impairment
□ Peritoneal diaysis	□ Assist with feeding	□ Cognitive impairment
□ Hemodialysis	□ Assist with dressing changes	□ Agitation or aggression
□ Bed bound	□ Turn every two hours	□ Cannot lie flat
□ Walker	□ Dressing changes (Freq ___)	□ Breathing difficulty
□ Wheelchair	□ Assist with medication (oral)	□ Fever
□ Bedside commode	□ Assist with insulin injection	□ Immunocompromised
□ CPAP	□ Assist with glucose monitoring	□ Pregnant
□ Suction	□ Wanders (confused)	□ Nausea, vomiting or diarrhea
□ Nebulizer treatments	□ Assist catheterization	□ Severe Pain
□ Service animal	□ Special diet: _____	□ Impaired equilibrium
□ Catheterization supplies	□	□ Addiction (not in remission)
□	□	□ >350 lbs (bariatric)
□	□	□
□	□	□
□	□	□

Medication and Problem List

Medications

Medication	Dose	Frequency	Has Medication	Immediate Refill Required
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO
			□ YES □ NO	□ YES □ NO

Problems and Current Needs

PROBLEM LIST	PROBLEM LIST	CURRENT NEEDS

Allergies

Equipment Brought by Resident

Notes Page

Date and Time	**Notes**

RESIDENT SIGN OUT STATEMENT

I HAVE RECEIVED ALL OF THE MEDICATION BOTTLES FOR CONTROLLED SUBSTANCES THAT I SHOULD HAVE, AND ALL OF THE MEDICAL EQUIPMENT THAT I BROUGHT WITH ME.

_____
RESIDENT SIGNATURE

_____
SHELTER OFFICER SIGNATURE